

comment

“The only person in the room you can ever change is yourself” **JOHN LAUNER**

“We need to be more skilled at exploring patients’ perspectives” **HELEN SALISBURY**

PLUS Austerity is a choice that will harm health

LAST ORDERS Rachel Clarke

Are women’s reproductive rights safe in the UK?

Six months ago this question might have seemed rhetorical or even outlandish, but then in June the US Supreme Court overturned *Roe v Wade*. At one stroke, the nearly 50 year old constitutional right to abortion was eliminated.

Like many in the UK, I found the news deeply disturbing. American women’s hard fought rights to bodily autonomy have been fatally imperilled by an unholy alliance of religious zealots and hard right forced birthers whose goal was not so much the promotion of “life” but the control of women’s bodies. Horror stories began to emerge, like that of a 10 year old girl in Ohio being impregnated by rape, then being forced to travel to neighbouring Indiana to have an abortion. But surely—like school shootings and reality show presidents—the lurid excesses of modern America could never happen here?

If only the facts inspired more confidence. Rishi Sunak, the prime minister, has abstained on all votes relating to abortion in England since becoming an MP. He did, however, vote in favour of new powers to impose commissioning of abortion services in Northern Ireland. Key members of his cabinet—the chancellor, Jeremy Hunt; the home secretary, Suella Braverman; and the foreign secretary, James Cleverly—have also abstained or voted against all English abortion legislation since 2015. Hunt has spoken about wanting to halve the time limit until which women can have abortions from 24 to 12 weeks, breaking the whip in 2008 to vote on such an amendment.

Then there is Maria Caulfield, Sunak’s minister for women. In 2019 Caulfield voted against legalising abortion in Northern Ireland. She supports cutting the abortion time limit, and used to be an officer in a parliamentary pro-life group. Incredibly, in interviews after her appointment, Caulfield doubled down on her opposition to the use of buffer zones, claiming protestors outside clinics might be there to “comfort” women attending the clinic. It’s almost as if Sunak is trolling us.

Contrary to popular belief, the right to abortion is not fully protected under UK law. The Abortion Act 1967 only partially decriminalises abortion, in cases where two doctors believe that continuing the pregnancy would be harmful to the physical or mental health of the woman or her existing children, an abortion would be less risky than continuing the pregnancy, or the risk is substantial that if the child was born it would suffer mental abnormality or serious physical disability. If these criteria are not met, women can be—and are being—prosecuted for having an abortion, with some even going to prison.

I want to believe a woman’s right to a safe and legal abortion is not under threat in the UK, but the degree of cabinet hostility to reproductive autonomy provokes deep and enduring unease in me.

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It’s almost
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OPINION Lucinda Hiam and
Danny Dorling

A return to austerity is not inevitable, it is simply a political choice

The policies outlined in the government's autumn statement should not be accepted but resisted if we are to protect the nation's already failing health

With last week's autumn statement the Tory government, via its chancellor Jeremy Hunt (above), is signalling a return to austerity, so it is timely to be reminded of two key points.

First, austerity is a political choice. It is not an inevitable or necessary burden that a country must bear, nor are the finances of a nation equal to that of a household. There is no "maxed out" national credit card, despite the ease that these kinds of metaphors provide for politicians when advancing their ideology. The UK government could choose instead to tax the wealthy more and put a higher proportion of gross domestic product (GDP) into public sector services, as almost all other European countries already do.* Reducing the threshold at which people begin to pay the top 45% income tax rate from £150 000 to £125 140 was tokenistic and not effective redistribution.

Second, austerity is very bad for health. The nations of the UK have been left behind when compared with other similar countries in terms of population health, even before the pandemic began. What was different about the UK between 2012 and 2019 was how deep austerity was and how high excess deaths were. Most areas of public spending, other than defence, will now see real term cuts in the coming years.

International organisations, including the UN, the Bank of England, and the International Monetary Fund (IMF), have warned the UK of the negative impacts of a return to austerity. It is extraordinary that



JUSTIN TALLIS/AP/GETTY IMAGES



Olivier de Schutter, the UN's poverty envoy, warned the prime minister, Rishi Sunak, that re-imposing austerity could "violate the UK's international human rights obligations and increase hunger and malnutrition." This does not appear to have been acknowledged by the government, nor has it raised the alarm that it should have done.

These warnings are entirely consistent with comments in 2018 from Philip Alston, the previous UN envoy, that the "callous" austerity policies caused poverty in the UK, and they were a political choice which inflicted "great misery." The Conservative's then prime minister, Theresa May, "completely disagreed."

Life expectancy

In the area of health, austerity has undeniably inflicted great misery. Health in the UK has been suffering since the previous round of cuts administered under the coalition government of 2010. Life expectancy improvements not only stalled but ceased completely for some, and now life expectancy has decreased for poorer groups and in poorer areas. Historically, sustained decreases in life expectancy improvements had not occurred in the absence of wide scale events such as pandemics, war, or natural disasters.

Another marker of population health, the infant mortality rate, has also been rising at times, and, when it didn't rise, hardly improved, with child mortality in the UK now among the worst in western Europe.

These changes are shocking and unprecedented. Yet, they are rarely reported

Child mortality in the UK is now among the worst in western Europe

or discussed in the media. Hardly any national newspapers reported the rise in maternal mortality in the UK in November that was primarily due to a rise in suicides among mothers to be and mothers shortly after giving birth. One local newspaper wrote: "This is horrifying, the government has committed to reducing maternal deaths, but laid bare these statistics show that not only are deaths rising but that the quality of care isn't improving."

The UK now has the highest maternal mortality rate when compared with seven western European countries. We have become so used to reports of the situation worsening that there is a danger we become complacent and resigned to this avoidable fate. Those who can are increasingly turning to private healthcare and hospitals.

The pandemic was so unprecedented that it would be expected to cause, and did cause, falls in life expectancy in all but a couple of dozen countries worldwide. The full impact is not yet known, but it is already clear that the UK is an outlier in its recovery, or lack thereof. Recent analyses have found that Britons have the worst access to healthcare in Europe, "soaring" rates of chronic illness, and a diminishing workforce. The cost of living crisis coupled with very high NHS staff shortages is worsening the situation further.

Many people from a range of backgrounds have been writing and



DOMINIC CLIPINSKI/PAJALAMY

warning about austerity since it was imposed after the 2008 financial crash. Fourteen years on, the evidence is indisputable of the harms caused. Yet, as a nation, once again we seem to accept it as a necessity. It is not. It is a choice, and a choice we should resist.

Miserly pensions

Even if the state pension and other benefits are increased by inflation, they will remain among the most miserly in all of Europe. They need to increase by more than inflation, as does the pay of nurses in the NHS. Higher paid workers in both the state and private sector should pay more tax—workers on similar wages across the rest of Europe already do.

A wealth tax is needed on the richest if we are going to turn the tide. Spain has recently introduced a second solidarity tax on its 23 000 wealthiest citizens. The UK is home to far more very rich people than Spain. There is a choice being made over who will suffer the most. But it seems neither of Britain's two main political parties is yet seriously considering the alternative that is needed.

Lucinda Hiam, DPhil candidate

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*The IMF estimates that in 2023 France and Belgium will spend 55% of their GDP on public services, followed in descending order by Finland, Greece, Austria, Denmark, Norway, Sweden, Germany, Spain, and finally both Portugal and the Netherlands at 45%, with the UK at only 41%. The 17 November autumn statement confirmed that the public spending position of the UK would probably worsen, and public debt interest payments rise.

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TALKING POINT John Launer

On being stuck

A lot of my work consists of supervision—not in the sense of training and managing people or telling them what to do, but instead offering a reflective space for them to consider their thornier problems. This kind of supervision is regarded as essential in some other professions dealing in complexity, such as social work. In general practice, and medicine more widely, it's far less common beyond the training years than it should be.

Recently I offered this kind of supervision to a young GP who felt stuck with a patient. He was seeing a woman with multiple symptoms that had eluded diagnosis or successful treatment. He was trying to help the patient see things in a different light—as the consequence of life experiences, perhaps, or in a way that might be tackled through her own strengths. Nothing he did or said seemed to make a difference. This is of course the familiar stuff of general practice.

Although he wanted my advice, I couldn't think of anything he hadn't already tried. I felt a strong urge to encourage him to let go. I wanted to explain that some people like his patient take years to change and he should stop beating himself up for failing to help.

But a small voice inside my head cautioned me that I was about to do exactly what he was doing with his patient—namely, trying to persuade him to alter his attitude. Why on earth should he do so, any more than his patient? We were in danger of getting stuck in a loop of futile attempts to mould others

in our own image. This kind of interaction is sometimes called a parallel process or “mirroring.” Good supervision often depends on identifying it and trying to avoid it.

As it happens, there was someone else in the room: another experienced educator I've often worked with. So I turned to her and explained my dilemma. I wanted to persuade my young colleague to change, I told her, just as he wanted to do with his patient. The other educator (you might call her my super-supervisor) listened and asked me some questions about my dilemma. The young GP listened in to our conversation too. And then something budged. He started to talk in a different way.

He explained his patient had suffered a tragedy some years ago and perhaps it was taking longer for her to come to terms with this than he expected. Even though he found their consultations frustrating, the patient always expressed gratitude and said their meetings brought some relief. The conversation with me, but especially my conversation with my colleague, had freed something. “It may take time,” he reflected.

I've had hundreds of conversations like this over the years. They don't work by offering magic but by resisting the temptation to offer it. They depend on listening to people's stories and carefully creating a space for them to evolve at their own pace. They also depend on recognising that the only person in the room you can ever change is yourself.

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Supervision doesn't work by offering magic but by resisting the temptation to offer it



The value of curiosity

One of the most inspiring teachers I encountered while learning to be a GP was a gentle man with a bright light in his eyes and excitement bubbling under almost every utterance.

He impressed not through brilliant diagnostic acumen (although I don't doubt that he had it) nor through his detailed grasp of the latest clinical guidelines (which were mercifully few in those days). The thing that stood out was his endless interest in his patients. He was captivated and intrigued—not just by their illnesses but also by their lives, and he clearly believed that by understanding their thoughts and motivations he could do a better job of helping them improve their health.

Some of what we do as doctors can proceed on a superficial, transactional level, including the many transient problems we encounter: fungal rashes; infected, ingrowing toenails; sprained ankles; even acute appendicitis. With these we can advise, treat, refer, and if we're lucky, solve the problem quickly. But many other health issues we see each day are complex and enduring, such as diabetes, high blood pressure, cancer, or depression. In these cases, how the patient thinks about their illness, and what they understand about the purpose and mechanism of the treatment, will make a difference to whether they decide to pursue the course their doctor recommends.

Their decision also depends on many other things—money for

prescriptions, how much their symptoms bother them, and their trust in the doctor—but any treatment plan must make sense to the patient. How many patients take their first packet of blood pressure tablets but don't request more, because they assume the problem is now cured? Explanations work only if they start from what the patient knows: if I have some understanding of the mental models my patients are working with, there's a better chance my suggestions will be adopted. Of course, care is needed in establishing this, as any attempt to get inside my patients' heads could come across as intrusive or just plain weird.

Much has been written about exploring patients' priorities—often including the suggestion that we pose unanswerable questions, such as “What matters to you?” But whatever we ask, we then need to convey a true interest in the patient as a person with their own rich life, into which our medicine must somehow fit.

We need to be more skilled and practised at exploring patients' perspectives and working with them, so together we can agree on the goal and treatments will be acceptable and effective. This takes time and is hugely helped by continuity of care, but while we have a shortfall of 4200 GPs and some of my colleagues report up to 90 clinical contacts a day, we'll struggle to live up to the bright eyed idealism of my former mentor.

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We need to convey a true interest in the patient as a person with their own rich life



LATEST PODCAST



Doctor Informed: The good and the bad of #MedTwitter

With Twitter's rocky change of ownership making headlines, the latest episode of the Doctor Informed podcast looks at whether #MedTwitter has been a positive or negative force. While many will credit Twitter for giving a voice to clinicians, it also comes with challenges, such as the potential for abuse and the spread of misinformation. Guest panellist Jonathan Guckian, a dermatology registrar and the director for social media and communications at the Association for the Study of Medical Education, talks about the shifting parameters of influence brought about by social media:

“One of the factors that makes social media so popular is that it's supposed to be flattening the hierarchy, although I prefer the term disrupting because the hierarchy isn't really flattened. It sometimes inverts hierarchies as well. A lot of people, if you gave them the choice of who would you believe about a fact: a professor with 10 followers and an egg for their profile picture, or a medical student who has a million followers and is sponsored by whatever brands? I think a lot of people would go for number two—in fact, I know they would, having interviewed them. And that comes down to social capital.”

Guckian gives his tips for doctors to look after themselves on social media:

“You have to practise good social media hygiene: have breaks, try to fight addiction, and curate the people you follow in a certain way as to promote positivity as well as negativity. At the minute, there's a reason there's a lot of negativity [on Twitter] because pay is rubbish, conditions are terrible, and there's another bin fire every five minutes. So sometimes you just have to turn it off. We also need to undertake proper research around this phenomenon because I do think it is the most important battleground for medical education for this generation and the next.”



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COVID INQUIRY

Understanding and neutralising covid misinformation and disinformation

Yuxi Wang and colleagues say that the public inquiry must look at who was opposing public health measures and why and should call on public health authorities to engage more effectively with the threats of infodemics

Much rests on the public inquiry into the UK's preparedness and response to the pandemic (covid19.public-inquiry.uk), with organisations and individuals scrutinised about the advice they gave and the decisions they made. The discussion will likely centre on the science, but it will also consider ideology, in particular the relation between individuals, society, and the state.

When is it justifiable to impose restrictions on one group of people to protect others, for example? Some people take the view that it hardly ever is. Throughout the pandemic, some people have opposed almost all measures introduced by governments at Westminster and in the devolved administrations, from the initial lockdown to mask mandates and vaccination certificates. Their messages are similar to those promulgated by adherents to an extreme libertarian philosophy that is now prominent in some sections of society in the US. Some benefit from generous funding from those opposed to what they term "big government,"^{1,2} and some of their messaging has been claimed

KEY MESSAGES

- Research on the political and commercial determinants of health points to the importance of understanding how evidence is generated and promulgated
- During the covid-19 pandemic, several groups have been active in opposing evidence based public health measures
- A rapid rise in misinformation and disinformation in digital and physical environments over a short period is called an "infodemic"
- Active management of infodemics must form part of a comprehensive pandemic response
- Further investigations into the social and public health effects of misinformation groups are needed to inform policy

1 in 4
YouTube videos
on coronavirus
contain
misinformation

1 Broadband Commission for Sustainable Development

In the UK
only 2%
of children
have the necessary
skills to detect
misinformation

1 UK's Commission on Race and the Teaching of Critical Literacy Skills



It can be difficult to get a complete picture of how evidence has been generated, framed, and presented

to include evidence that is fabricated, distorted, or taken out of context.³

Inevitably, given the complex technical issues involved, differentiating fact from fiction can be difficult. One argument asserts that, because everyone has vested interests, including those promoting public health, all sources should be treated the same way. This was set out in the Brussels Declaration, which was drafted with substantial input from the tobacco and alcohol industries.⁴ But there is now a large body of evidence from researchers working on the commercial determinants of health that contradicts this,⁵ emphasising the importance of seeing the full picture, including who says what and that which is not said.⁶

The covid-19 inquiry team has now reported on the consultation about its terms of reference. Those analysing the responses found that 15% of submissions were "campaigns and duplicates."⁷ This raises the question of what a campaign is. When different groups submit versions of the same text, the connection is obvious. But other links are less obvious: for example, the BBC reports that UsForThem, which has attracted high level support from politicians in its campaign against restrictions in schools, has links with the Health Advisory and Recovery Team (HART), which in turn has worked on a campaign against children being vaccinated against covid-19.⁸⁻¹⁰ HART, meanwhile, shares members with groups that have opposed vaccination, such as the UK Medical Freedom Alliance and the Children's Health Defence.

Lady Hallett, an experienced judge and chair of the covid-19 inquiry, will be accustomed to assessing the veracity and quality of evidence presented. But it can be extremely difficult to get a complete picture of how evidence has been generated, framed, and presented.¹¹ Understanding how the tobacco industry has distorted science, for example, has only been possible by having access to a trove of internal documents released under court order in the US.¹²

Leaked online chats among individuals affiliated with some of the groups cited above shed light on links among campaigners against interventions to tackle covid-19 and some politicians, journalists, and members the scientific community.⁹ If the inquiry is to obtain a full picture of events during the pandemic, then it would benefit from seeing these chats. Fortunately, they are now in the public domain.

Infodemics—a key part of pandemic management

There are two types of misleading information: misinformation and disinformation. They differ in terms of intent; the latter is created with the intention of deceiving. Without additional information, such as the tobacco industry documents mentioned above, it can be difficult to differentiate between them. Their spread—often referred to as an “infodemic”—is now widely acknowledged to be a threat to the global efforts towards ending the pandemic.¹³ In times of crisis, people are more susceptible to misinformation, disinformation, and conspiracy theories probably because their important psychological needs are unfulfilled, leading to frustration.¹⁴

Covid-19 related misinformation and disinformation spread through society from the top down and the bottom up. One study identified politicians, celebrities, and other prominent public figures as sources of covid-19 misinformation and disinformation.¹⁵ Even though these sources produced only about 20% of the misleading information, they accounted for 69% of total social media engagement.¹⁵

Further evidence on the critical role of politicians in driving covid-19 misinformation and disinformation comes from a comprehensive survey of the traditional and online media landscape.¹⁶ The authors concluded that Donald Trump was “likely the largest driver of the covid-19 mis/disinformation ‘infodemic,’” accounting for 37.9% of mentions in the content of identified news articles.¹⁶ The Center for Countering Digital Hate, a non-profit organisation based in the UK and the US, analysed over 812 000 posts from Facebook and Twitter in the first quarter of 2021 and identified 12 people responsible for 65% of covid-19 anti-vaccine content, who they dubbed the “disinformation dozen.”¹⁷ These people include physicians who are alleged to have turned to pseudoscience, anti-vaccine entrepreneurs promoting alternative treatments, and organisations that have long opposed childhood vaccination.

Misinformation and disinformation manufactured and spread by the public can also generate substantial engagement,^{15 18} so strategies aimed at tackling infodemics should target both top-down and bottom-up spread. In doing so, it is essential to understand the nature of any misinformation and disinformation being promoted as it has the potential to spread fear and possibly cost lives.¹⁹

A substantial majority (88%) of the false or misleading claims identified by Simon and colleagues were on social media platforms; television, news outlets, and other websites accounted for 9%, 8%, and 7%, respectively.¹⁵ The misleading content that received the highest engagement (29%) typically contained a small degree of accurate information that was re-contextualised and twisted; misinformation and disinformation that included doctored images and videos received the next highest (24%).

Evanea et al looked at 38 million traditional media news articles published in English worldwide. The top three most prevalent misinformation, disinformation, and conspiracy theories related to miracle cures for covid-19, conspiracies involving “deep state” actors paying prominent figures associated with the response to covid-19, and the US Democratic party manufacturing covid-19 to coincide with Trump’s impeachment. The Wuhan laboratory being a secret bioweapons facility, Bill Gates having foreknowledge of the pandemic, and 5G technology having deleterious health effects were also mentioned.¹⁶

A national survey of US adults further investigated the popularity of different types of misinformation.²⁰ It showed that conspiracy theories endorsed by visible partisan figures received higher levels



A study concluded Trump was likely the largest driver of the covid-19 mis/disinformation infodemic

of support, measured by participants’ beliefs in the misinformation, than non-partisan medical misinformation about the treatment and transmission of covid-19.²⁰ This indicates that people are more likely to believe abstract theories about the nefarious motives of political figures than they are to believe potentially harmful but non-ideological health misinformation.²⁰

Moreover, misinformation and disinformation with a higher degree of generalisability are more likely to get traction than specific information; 29% of Americans believe that the number of covid-19 deaths has been exaggerated, whereas only 13% of Americans support the claim that Bill Gates is responsible for the pandemic.²⁰

What can be done?

The inquiry must identify lessons that can be learnt before the next pandemic. One such lesson is likely to be the need to develop strategic approaches to tackle disinformation and conspiracy theories. Long before the existence of social media platforms, researchers investigated how to mitigate the effect of exposure to false information.^{21 22} Traditional measures used in the past include exposure to corrective advertising through mass media, content labelling on consumer products,²³ and correcting misinformation and disinformation about certain public services.²⁴

The advent of social media and online platforms has provided a fertile medium for disinformation to flourish. Recent studies have looked at the effectiveness of several types of intervention, including redirection, content labelling, content distribution and sharing, disinformation disclosure, disinformation literacy, advertisement policy, content or account moderation, and security and verification.

One literature search examined studies on the effectiveness of different types of countermeasures against disinformation campaigns.²⁵ Looking at outcomes such as beliefs, intended behaviour, knowledge, and observed behaviour, the studies indicate that fact checking can reduce the influence of exposure to false information on people’s beliefs as well as their propensity to share misinformation and disinformation.²⁵ In terms of fact checking interventions, most of the included studies evaluated the effects of disinformation disclosure, which is when the platform informs a user that they have come in contact, shared, or interacted with disinformation; many others studied content labelling using a fact checking tag, funding tag or outdated tag, and some examined interventions that educate users to identify disinformation.²⁵

Although most of these countermeasures have proved effective, they don’t represent the major interventions used by social media platforms in the real world, such as content moderation (removal or suspension of account or content).²⁵

Using randomised experiments based on a hypothetical scenario that includes information that is later refuted, two studies in cognitive psychology identified a “continued influence effect” of

misinformation.^{26,27} Even after retraction or warning that certain information was incorrect, the retracted facts continued to stick to memory and shape how some people interpreted events.^{26,27} Schmid and Betsch conducted six experiments to assess how to mitigate the influence of science deniers on an audience.²⁸ The participants were randomly assigned to different levels of rebuttal conditions after being exposed to a public discussion with a science denier of vaccination or climate change.²⁸

The internal meta-analysis across all six experiments shows that not responding to science deniers decreases attitudes to behaviours supported by science (such as vaccination) and reduces intentions to perform these behaviours.²⁸ They also found that providing facts or uncovering rhetorical techniques, such as conspiracy theories, false experts, and impossible expectations, tend to be the most effective and universal tool for science advocates.²⁹ But the risk of backfire effects—in which correction of a falsehood can reinforce belief in it among those whose beliefs or political ideologies are threatened by the facts—must be considered.^{24,30}

Another approach is psychological inoculation or “prebunking”—exposing people to a weakened dose of a persuasive but false argument to trigger the “immune system.”³¹ Studies have shown that inducing people to think about accuracy or inoculating against misinformation and disinformation can reduce susceptibility and sharing.³⁰⁻³³ When reading this literature, however, one must differentiate the effects on beliefs, intended behaviour, and knowledge.²⁵ Moreover, the existing literature primarily reports on experimental designs in laboratory or survey settings, with relatively little research on real world behaviours.^{26,34} Empirical studies on the nature of and countermeasures against groups promoting misinformation and disinformation that have gained political and social influence are still lacking.

Finally, legal interventions are being experimented by governments in the real world. A bill in California will allow regulators to punish doctors for spreading false information about covid-19 vaccines and treatments by revoking the licence to practise.³⁵ A separate bill seeks to require online platforms such as Facebook to disclose publicly their algorithms on content moderation to determine how disinformation is amplified.³⁶ Given the lack of transparency in allowing academic researchers to examine the potential harms of these platforms, more regulatory actions may be the appropriate course of action.

Inducing people to think about accuracy or inoculating against misinformation and disinformation can reduce susceptibility and sharing

QUESTIONS FOR THE PUBLIC INQUIRY

- To what extent were groups promoting contrarian messages against scientific evidence able to influence policy?
- How effective was the government in countering misinformation and disinformation campaigns (and did they draw on cognitive psychology and media studies)?
- To what extent did weaknesses in public messaging leave space for online misinformation and disinformation to take hold?



What should the inquiry focus on?

The public inquiry should do three things. First, it should examine the extent to which groups promoting contrarian messages were able to influence policy. We think it unlikely that they were able to do so directly but, given their links to the media and influential politicians, they should be investigated.

Second, it should inquire into how effective the government was in countering misinformation and disinformation and whether it drew on cognitive science to devise interventions. Data from the Association of School and College leaders, for example, indicate that eight in 10 schools were targeted by anti-vaccine protesters.³⁷ Protests also targeted parents and students at school gates. The inquiry should examine whether steps were taken to mitigate the impact of these protests, such as disclosing rhetorical techniques these groups employed to induce fear among parents.

Third, to what extent did weaknesses in the government and public health organisations’ messaging (around masks/childhood vaccines) leave space for online misinformation and disinformation to take hold?

Discussion

Historically, science denialism has caused people to refuse preventative measures like immunisation or life saving HIV/AIDS medications, which has distorted attitudes and resulted in years of severe illness and death.^{28,38} Recent false or misleading covid narratives promoted by some groups to discredit legitimate public health measures, in particular non-pharmacological interventions, may have likewise contributed to preventable illness and death and those responsible must be held legally accountable. Children who could have been protected (as in many other European countries) have been unnecessarily exposed to a virus that can have long term effects on many organs in the body. Long covid has risen substantially in children and young people³⁹ after consecutive waves of infection. The scientific community and government institutions are not immune to dangerous ideologies and influence operations.

We hope the information we have included here—on the nature and activities of groups that have opposed measures to reduce transmission of covid and what can be done to tackle them— will be of use to the inquiry. Fact checking and labelling sources of information clearly have a role. Maybe public health authorities should also do more to expose the methods used by groups promulgating misinformation and devise more effective ways to counter their messaging. The existing Online Safety Bill, recently introduced to the House of Commons, should also explicitly list those who have benefitted financially from the spread of covid-19 related misinformation and disinformation.⁴⁰ Politicians and parliamentary committees seeking scientific advice must also be transparent about how advisers and experts are chosen, especially when partisan narratives are prominent.

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LETTERS Selected from rapid responses on bmj.com

LETTER OF THE WEEK

Putting the cart before the horse



The continuous flow model (or proactive flow model) transfers patients from the emergency department into wards irrespective of whether beds are free (This Week, 29 October). It aims to be a solution to problems of bed occupancy, lack of ward discharges, overcrowded emergency departments, and ambulance handover—but which of these problems is it really trying to solve?

The demands of the health and social care service far exceed its capacity, with the most substantial bottleneck being patients who are fit for discharge awaiting social care support. A proactive model used to increase bed capacity might have marginal success in the short term, but as it tackles neither demand nor community discharge capacity, surely those extra beds would be rapidly filled with limited improvement to flow.

A proactive model is likely to contribute to “failure demand”—an increased demand on our resources caused by unknown risks associated with moving patients to overcrowded wards (further fragmented care, falls, infections, unrecognised deterioration, harm, increased length of stay, and so on). It may also be associated with “capacity detractor”—further pressures on beds, staff, imaging and investigations, compassionate care capability, and so on. Thus, if a proactive model is used to solve the wrong problem, it could certainly worsen the outcomes for our patients.

If a lack of emergency department cubicle space (rather than a lack of senior staff or hospital beds) is the cause of delayed ambulance handovers, overcrowding, and delayed treatment and admission, the risks of proactive flow might be worth it. Delayed treatment of patients in the emergency department is associated with worse clinical outcomes and thus also contributes to failure demand.

With winter looming, I wonder whether we are spending too much time thinking about the solution and not enough time thinking about where the true problems lie?

Aranghan Lingham, Darzi fellow in clinical leadership, Gillingham

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CANCER BACKLOGS

Centralisation versus “distance decay”

Aggarwal and colleagues argue against “shopping around” to tackle the backlogs of patients requiring specialist cancer care (Analysis, 29 October).

Specialised services have been centralised to guarantee quality. But does the increment in quality from centralisation outweigh the decrement in receipt of service caused by “distance decay”? This term describes how patients are less likely to receive a timely diagnosis and treatment when the relevant facilities are located further from their home.

Much of the argument supporting centralisation comes from comparison between low and high volume hospitals in the US. An NHS district general hospital has the workload of a medium to large American institution. As Aggarwal and colleagues point out, quoting Sajid Javid, choosing to travel for care is characteristic of residents of “leafy suburbs.” Similarly in the US, large volume hospitals attract well favoured patients from a wide area; these are not realistic examples of optimal care.

S Michael Crawford, clinical lead for research, Airedale General Hospital

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SURVIVING THE NEW NORMAL

The new normal is not good enough

Coombes suggests that NHS staff and patients will have to cope with the “new normal” after the covid-19 pandemic and the previous deterioration in healthcare provision (Editor’s Choice, 5 November). Some patients might welcome video calls, but my experience as a volunteer at a local cancer support charity tells a different story.

Some people still learn their diagnosis of cancer by a telephone call from the hospital consultant or GP. When they need more information before reaching decisions about treatment, a face-to-face discussion with the surgeon or oncologist is not available. And when the start of treatment is postponed at less than 24 hours’ notice with no explanation and only the promise of a letter with a new date, confusion and anxiety increase, and confidence in the NHS is undermined.

If this is to be the new norm, it is not good enough. Much more than “ministers’ attention” is urgently required.

Reginald Hall, retired urologist, Newcastle upon Tyne

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PHARMACISTS IN SERVICES FOR MINOR AILMENTS

Joined up electronic systems are lacking

I welcome initiatives to expand the delivery of healthcare in the community (This Week, 29 October). Prescribing pharmacists embedded in general practices using the same electronic record system offer great potential, but we should perform a robust evaluation before increasing prescribing outside of GP systems.

The absence of joined up electronic systems risks further fragmentation of continuity of care in general practice, might increase the risk of adverse drug reactions without accurate knowledge of what has been prescribed, and can lead to de-investment in general practice, which is already under-resourced.

Systems also need to be developed to reach agreement when different opinions of clinical management emerge and to deal with potential conflicts of interests that might arise from prescribing and dispensing in the same community pharmacy. Such schemes should be done in partnership with GPs and pharmacists, with an independent evaluation to generate the evidence to support policy decision making.

Daniel Morales, academic GP, Dundee

Cite this as: *BMJ* 2022;379:o2753



BENEFICIAL EFFECT OF EXERCISE ON SOCIAL CARE

A new culture of healthy living

McNally's article about the crisis in social care was reassuring (Scarlett McNally, 29 October). Most people who need social care are frail and older—but frailty is not inevitable. Frailty is caused by loss of muscle strength and low cardiorespiratory fitness, both of which are associated with lack of exercise over a very long period.

The Department of Health and Social Care should be to lead a charge for increased physical activity among all people, starting with younger people. We have many exercise promoting organisations that could be marshalled to promote a new culture of active living.

Regular exercise increases health span and reduces the period of terminal morbidity and dependence at the end of life. To be inactive should become the new smoking—an unacceptable cause of disease and threat to good health. The medical profession could lead the way, just as it was the first group to eschew cigarettes.

Hugh J N Bethell, retired GP and director of exercise, Alton

Cite this as: [BMJ 2022;379:o2765](#)

A walk a day keeps the doctor away

All healthcare providers should reinforce the benefits of regular exercise. Regular exercise is well known to act as a primary preventer of disease, improving longevity, affecting morbidity, and reducing healthcare spend by its effects on all cause mortality.

Physiological science has improved the art of exercise prescriptions by identifying elements of aerobic, anaerobic, and resistance activity that will have the greatest effect on health. But these can be overwhelming for busy clinicians and their patients. Simple messages such as walking to the shops regularly and carrying a light load home might have the same physiological effects and

health benefits as an exercise prescription. Similarly, recreational activities such as gardening, fishing, and golf will confer substantial benefit to personal health.

If enough people engage in these pleasure pursuits, they will impact positively on the escalating exchequer spend on healthcare. To paraphrase Hippocrates, "A walk a day keeps the doctor away."

Conor P O'Brien, consultant physician in sports and exercise medicine, Blackrock

Cite this as: [BMJ 2022;379:o2773](#)

Active choices should be easier

The promotion of physical activity should be part of a comprehensive long term strategy. We are pleased that members of the House of Lords and House of Commons have debated the lack of participation. But physical activity is not being prioritised in government policy making. It is not protected in the school curriculum, and in some areas playing fields have been sold off. Local authorities have cut budgets for open spaces and recreation facilities.

An important goal for the government should be to integrate physical activity into the way people live so that the active choices become the easier ones. We need to enable people to participate in sport and to lead active lifestyles regardless of ability, age, and background. This will require changes to the physical and social environments.

Perhaps now is the time to boost spending on the promotion of physical activity to try to mitigate some major future costs.

Michael Craig Watson, trustee; John Lloyd, honorary vice president, Institute of Health Promotion and Education

Cite this as: [BMJ 2022;379:o2780](#)

HEALTH PROFESSIONALS AS COACHES

Coaching: a personal touch

Morgan asks whether health professionals should be viewed as role models or coaches in regard to healthcare advice (Matt Morgan, 22 October). Like most discussions around healthcare, it is important to be patient centred. Are patients who are struggling with their diet, smoking, or alcohol intake more likely to listen to a teetotal marathon runner or someone who has personally struggled with one or more of these problems? Studies have shown that doctors perceived as overweight, might be seen as less credible. Should health professionals tackle this?

If discussing sensitive issues from a personal point of view helps to improve the doctor-patient relationship, and thus improve health outcomes, then this should happen. If they are not discussed, we are providing an inferior treatment. One of the most important characteristics of any coach is personal experience. We should not shy away from using this to do the best for our patients.

Patrick A J Briggs, foundation year 2 junior doctor, Liverpool

Cite this as: [BMJ 2022;379:o2728](#)

COP27 CLIMATE CHANGE CONFERENCE

Land trauma and land based violence

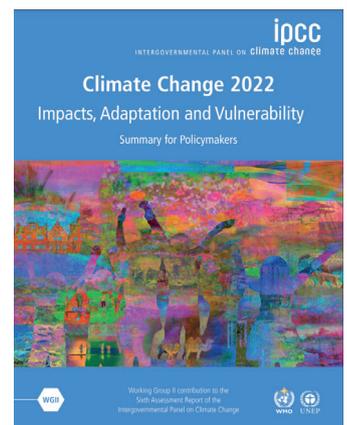
Atwoli and colleagues overlook that climate crises with catastrophic health effects are occurring within communities, not borders (Editorial, 29 October). Their editorial does little to serve justice in terms of recognising the role of indigenous knowledge in supporting the world's vulnerable communities from the effects of climate change.

We conceptualise two major observations about mental distress from environmental change and land rights issues—land trauma and land based violence. These concepts reflect ways that the communities we are working with experience transgenerational and contemporary traumas and violence that have targeted their lands and the wellbeing of those who identify themselves to be part of the land.

We need to integrate definitions of violence, including understanding that violence can be committed against the land as well as people. Then, we can begin to understand the plights that communities worldwide are fighting to be seen, heard, and acted on.

Ayesha Ahmad, reader in global health humanities, London; Victoria Pratt, creative director, Invisible Flock; Samrawit Gougsa, head of communications, Minority Rights Group

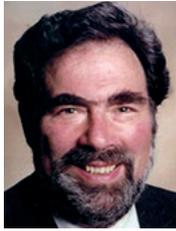
Cite this as: [BMJ 2022;379:o2790](#)



OBITUARIES

James Michael Gumpel

Consultant physician (b 1936; q Oxford/London, 1960; FRCP Lond), died from heart failure on 5 October 2022



James Michael Gumpel (“Michael”) and first wife, Shirley Fisher, were both awarded fellowships at the Johns Hopkins Hospital in Baltimore, USA, from 1962 to 1965. On returning to London, Michael was appointed consultant physician specialising in rheumatology and acute care medicine at Northwick Park Hospital from its opening in 1970, and he remained there until his retirement from the NHS in 1997. He pioneered treatments and was coauthor of 129 papers listed in PubMed between 1967 and 2003. Michael and his second wife, Carole, ran his private practice in Harley Street and at the Clementine Churchill Hospital until 2007. Michael leaves Carole, three children; a stepson; and 10 grandchildren.

Nicky Carling, Sophie Watkins, Jonathon Gumpel

Cite this as: *BMJ* 2022;379:o2661

Philip John Nolan

GP (b 1937; q Manchester 1962; FRCGP), died from complications after a fall and spinal cord injury on 15 July 2022



Philip John Nolan started as assistant GP in the Lockwood practice in Huddersfield in 1964 and stayed until he retired in 2002. In 1975 he attended the Nuffield Course for course organisers in general practice education. In 1976 he became a course tutor and later was appointed course organiser. In 1991 he became joint associate adviser in general practice, supervising postgraduate education and vocational training in the Yorkshire region until 2000. Philip had a passion for innovation and improvement. In the early 1990s he and his partners moved to a new purpose built surgery, designed to provide patients with a range of healthcare services under one roof. Philip leaves Evelyn, his wife of more than 58 years; five surviving children; 12 grandchildren; and six great grandchildren.

Margaret Nolan

Cite this as: *BMJ* 2022;379:o2660

Herbert Augustine Harcourt Melville

Consultant obstetrician and gynaecologist (b 1930; q Cardiff, 1954; FRCS (Ed), FRCOG), died from old age on 23 September 2022



Herbert Augustine Harcourt Melville (“Herb”) was born in Barbados. In 1948 he left for Canada to study engineering at McGill University. After the first year he accepted a place to study medicine at Cardiff Medical School, where he met his future wife and fellow medical student, Betty Williams; they married in 1955. Their honeymoon in Barbados was interrupted by Hurricane Janet and he continued working for the remainder of the year at what was then the Barbados General Hospital. On their return to England Herb took up registrar posts in obstetrics and gynaecology in Birmingham and Leeds. In 1966 he was appointed consultant in obstetrics and gynaecology in Brighton. Herb leaves Betty, two children, and five grandchildren.

Elizabeth Fisher, David Melville

Cite this as: *BMJ* 2022;379:o2692

Michael Edward Shipley

Consultant rheumatologist, University College Hospital, London (b 1948; q Cambridge/King’s College London, 1973; MD, FRCP), died from metastatic bowel cancer on 15 July 2022



Michael Edward Shipley (“Mike”) was appointed consultant rheumatologist at the Middlesex Hospital in 1982. He was an excellent physician and a kind and inspiring leader and mentor. He developed an interest in chronic pain and was involved with the British Association for Performing Arts Medicine. With help from colleagues he set up a unique MSc in performing arts medicine at University College London. He was always interested in medical politics (which he called medical diplomacy) and took many roles within UCLH. Opera was a lifelong passion which he shared with Philip, his partner of 39 years. During the final stages of his illness, singers from the English National Opera performed at his bedside. Mike leaves Philip; his sister, Carolyn; and his two nieces.

David Isenberg, Jessica Manson

Cite this as: *BMJ* 2022;379:o2717

Laurence Hugh Morgan

Consultant ophthalmologist (b 1954; q Liverpool 1977; FRCS Ed, FRCOphth, FRCS Eng), died suddenly from a heart attack on 14 June 2022



Laurence Hugh Morgan was born in Nottingham. After completing his ophthalmology training at the Manchester Royal Eye Hospital, he worked as a consultant ophthalmologist at the Stepping Hill Hospital in Stockport. Colleagues and patients held him in high regard, and his junior trainees and nurses respected him a lot for his encouraging support in improving their clinical and surgical skills. A dedicated family man, he moved to Wales after retiring. His love of ophthalmology brought him back from retirement to provide part time support to the ever busy eye unit in Abergele. He died suddenly from a heart attack at home. Laurence married Elisabeth in 1981, and leaves her, their three children, and two grandchildren.

Nikhil Kaushik

Cite this as: *BMJ* 2022;379:o2695

Kia Soong Tan

Consultant respiratory physician University Hospital Wishaw (b 1966; q Glasgow 1989; MD Glas, FRCP Glas), died from metastatic prostatic carcinoma on 5 July 2022



Kia Soong Tan was born in Taiping, Malaysia, and after his primary schooling there attended Fettes College in Edinburgh. At university Soong met Linda, a fellow medical student, who became his wife of 26 years. In 1999 he graduated with an MD, and from this body of work he generated several high impact index papers published in journals. After completing his clinical training he took a locum consultant post at Dunedin Hospital, Otago, New Zealand. In 2002 he was appointed consultant respiratory physician at University Hospital Wishaw. His patients were always his over-riding priority. His commitment continued throughout the covid-19 pandemic, and only when he became unwell in 2021 was he forced to retire early. Soong leaves Linda and two sons.

Linda Stephen, Kia Meng Tan

Cite this as: *BMJ* 2022;379:o2662

Michael Sanders

Neuro-ophthalmologist who diagnosed Jane Austen's cause of death

Michael David Sanders (b 1935; q Guy's Hospital, London, 1959; FRCS, FRCP, FRCOphth), died from cancer of the pancreas on 25 July 2022

Born in Ceylon, now Sri Lanka, where his parents ran a tea plantation, Michael David Sanders enjoyed a happy childhood. In 1942 he travelled to safety in South Africa with his mother and brother. He returned to Sri Lanka after the second world war, before coming to England for schooling.

At 18 he joined Guy's Hospital as a medical student. After his house jobs he joined P&O as an assistant surgeon on *SS Strathmore* and visited his parents in Sri Lanka, sailing to and from Australia. On his return to dry land, Sanders applied to train in neurosurgery at the Maudsley Hospital. He spent a year learning general medicine at Balham Hospital and did three years' further training at Moorfield's Eye Hospital.

In 1967 he won a Medical Research Council fellowship to study in San Francisco. On his return, he was

appointed consultant neuro-ophthalmologist, first to the National Hospital of Neurology and Neurosurgery, Queen Square, and then, a year later he joined John Winstanley at St Thomas' Hospital. In 1973 St Thomas' Hospital merged with the Royal Eye Hospital.

Teaching and research

For the next 30 years at Queen Square and St Thomas', Sanders saw patients, taught students, delivered lectures, ran conferences, conducted research, and published widely. An extrovert, with a warm, generous nature, he enjoyed hosting parties with his wife, Thalia, to welcome the arrival, departure, or successes of members of staff. He quickly built an international network of visiting professors from Australia, Europe, and North and South America.

He founded neuro-ophthalmology—the study of the effects of brain disease on the eyes—as an ophthalmological subspecialty in this country, published more than 180 peer reviewed articles and gave seven prestigious lectures. With

Sanders founded neuro-ophthalmology as an ophthalmological subspecialty in the UK

the aid of advanced computer technology, he helped to revolutionise the diagnosis of many forms of eye disease and, together with Timothy Ffytche, helped pioneer the use of fluorescein angiography to study diseases of the blood vessels in the retina and optic nerve.

Jane Austen

A resident of the village of Chawton in Hampshire, Sanders lived in sight of Jane Austen's house for over 20 years and had a keen interest in her works. He was a lifelong member of the Jane Austen Society. In his retirement, assisted by Elizabeth Graham, Sanders made a new diagnosis of the cause of Austen's premature death, over 200 years ago, at the age of 41, from lupus. After her death, Austen's letters were censored and some destroyed by her sister, Cassandra, who was desperate to preserve the privacy of her sister. Fortunately, for Sanders and Graham, the remaining available letters had enough clues to sustain a diagnosis. By reviewing all of these and extricating relevant medical information, with their usual meticulous attention to detail, they put forward a convincing case, published in *Lupus*, that Austen did not die of Addison's disease or lymphoma, as was widely held, but that she died of systemic lupus erythematosus, an autoimmune disease that involves multiple systems. Some 90% of patients are female and it has a high mortality.

During an interview for the Chawton House Society in 2021, Sanders said, "Lupus is

a terrible disease for women. Austen died about 11 months after her first symptoms, and in the most recent British studies female patients died on average 3.8 years after diagnosis, despite treatment. Current treatment greatly extends life expectancy, thanks to steroids. Austen had the same disease that is currently recognised, and she even conforms to the international criteria as recognised today. I started reviewing every letter to cover Austen's whole history, and her main and most frequent symptom was of rheumatism. The skin tone in Addison's disease is progressive tanning, often to a dark colour, of the whole body and is permanent. Her lesions were multicoloured, transient, and on the face. So the skin was not typical of Addison's. Only two conditions produced pigmentation and recovery, and the condition that affects the face is lupus. Austen therefore had two of the main symptoms of lupus."

The abstract of the paper concluded: "We have reviewed all of Austen's available letters and extricated relevant medical information which reveal rheumatism, facial skin lesions, fever, and marked fluctuation of these symptoms. The severity of these symptoms increased, leading to her death within a year. This range of clinical features fulfils the most recent classification criteria for systemic lupus erythematosus."

It was fitting that an article on his final paper on Austen's death was published in the *Telegraph* a few days before he died peacefully. He leaves his wife, Thalia, and their two children.

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